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Op-Ed

The Future of the World Health Organization: Lessons Learned From Ebola

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This year's World Health Assembly (WHA) was critically important to the future of the World Health Organization (WHO). The 68th Assembly took 3 major steps to improve global health security: a global health emergency workforce, an emergency contingency fund, and a review of the International Health Regulations (IHR). Sadly, it failed to address WHO's deep structural problems, which could threaten its legitimacy for a generation. The question asked by the WHO Independent Panel in July was how to make the Organization fit for purpose, including transformations in culture, leadership, and funding.[1]

The Global Health Emergency Workforce

The absence of a robust domestic workforce represented a signal failure of the response to the Ebola outbreak in West Africa. The 3 afflicted countries—Guinea, Liberia, and Sierra Leone—had the world's lowest health worker-to-patient ratios and lost more than 500 health workers during the epidemic.

Consistent with its constitutional function spelled out in Article 2(d) to furnish aid in emergencies, the assembly will launch a global health emergency workforce in January 2016. The emergency workforce will be drawn from existing networks, including the Global Outbreak Alert and Response Network (GOARN), the Global Health Cluster, and foreign medical teams. An effective response requires a range of human resources: clinicians; public health professionals; and experts in communications, culture, and behavior. These work skills need to be ensured through comprehensive training and certification.

Importantly, major barriers to effective deployment must be dismantled, including expediting visas for foreign workers, granting permits

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to offload medical and humanitarian supplies, and arranging medical evacuation for workers who contract infectious diseases. Despite the critical importance of training, medical supplies, and logistics, WHO is implementing this emergency workforce without new dedicated funds. It is hard to conceive how such a complex operation can be conducted without a major injection of resources.

An Emergency Contingency Fund

In 2011, a WHO independent committee proposed creating a $100 million contingency fund, which the assembly never adopted. The director general's (D-G's) strategy was to mobilize international funding when an emergency struck. But the organization should have realized that once a rapidly moving infectious disease emerges, it is too late to begin resource mobilization, as occurred with Ebola.

Article 58 of WHO's constitution stipulates that a special fund be established to meet emergencies and unforeseen contingencies. After the outbreak of Ebola, the organization made plans to launch a "specific, replenishable contingency fund . . . with a target capitalization of $100 million."[2] Notably, the fund will be financed by flexible voluntary contributions, but not additional core funding through mandatory assessed dues. The contingency fund is important. But considering the billions of dollars in humanitarian assistance and the loss in the most affected countries of approximately 12% of their GDP, $100 million seems incommensurate with the need.

The trigger point for deploying the fund is also important. The D-G was heavily criticized for delays in declaring a Public Health Emergency of International Concern (PHEIC) under the International Health Regulations (IHR). Wisely, the release of the contingency fund would not be tied to a PHEIC declaration. Instead, the agency plans to use the Emergency Response Framework's grading system as the trigger for drawing down the contingency fund. The assembly ultimately left the decision to the D-G to deploy the emergency fund.

The International Health Regulations

The IHR are the key international legal instrument for governing global health emergencies. Yet, the Ebola epidemic revealed deep

flaws in IHR compliance and effectiveness. The 68th Assembly directed the D-G to establish an IHR review committee to assess their functioning, transparency, effectiveness, and efficiency. Despite well-understood deficiencies, the assembly made no decisions and allocated no resources.

Three IHR reforms are urgently required.

First, despite the mandate to develop core health system capacities, only 64 of the 196 states parties informed the secretariat that they had achieved these core capacities; 81 requested extensions; and 48 did not even communicate their status or intentions.[3] States, moreover, are allowed to self-assess their status. The IHR should insist that states invest in building capacities and require WHO to rigorously evaluate their performance.

Second, the D-G did not declare a PHEIC until 6 months after the first international spread of Ebola and months after Médecins Sans Frontières (MSF) had urged such a declaration. Leaked internal documents demonstrated that the D-G was under political pressure not to declare an emergency.[4] The composition and deliberations of the IHR committee that advises the D-G are undisclosed, undermining the transparency and public accountability required of an international organization. Instead of an all-or-nothing declaration of a PHEIC, the response should be graduated as an outbreak becomes more serious. Simultaneously, IHR committee deliberations should be open and accompanied by an independent "shadow" committee to advise the D-G.

Third, the D-G's recommendations to states parties have been widely ignored, including bans on travel, trade, and the enforcement of quarantines. There are no incentives or compliance mechanisms, and the D-G does not single out states that fail to adhere to their international obligations.

Deeper Structural Reforms

WHO has a critical shortage of funding and does not control the majority of its budget. Yet, the assembly did nothing to change the agency's underlying fundamental funding flaws. The 2016/2017 budget is $4.385 billion, a 10.3% increase.[5] This level is wholly incommensurate with its worldwide mandate, lower than the budget of many major hospitals in the United States. Mandatory assessed dues remain at their 2012/2013 level, which represents zero nominal growth and accounts for 21% of the

program budget. Voluntary contributions by member states and large donors (eg, the Gates Foundation) account for the remaining 79%. The WHO's budget, therefore, is not only inadequate to meet global health needs, but the D-G controls just 21% of the budget, so that external donors dictate the organization's priorities and action agenda.

The assembly also did not change WHO's regional structure, despite the tensions between headquarters and the African regional and country offices, which blocked visas for foreign aid workers and failed to rapidly issue permits to offload critical medical supplies. If WHO is to fulfill its constitutional mandate to lead and coordinate the global response, its different levels need to have greater coherence. Yet the assembly did not alter the method of appointing regional directors or develop concrete reforms to ensure greater worldwide coherence in operations.

Additionally, the assembly did not adopt a conflict-of-interest policy for businesses such as those manufacturing food and alcoholic beverages. More important, it did not reform its governance to harness the creativity of civil society. The Global Fund, GAVI Alliance, and UNAIDS all include civil society in their governance decisions, but the WHO remains an outlier. What the AIDS experience taught us is that harnessing the creativity and advocacy of civil society can lead to transformational change.

I propose that the assembly create a special chief operating officer to ensure fundamental reform of the organization's funding and governance. It is clear that the D-G is too politically influenced by member states to make the bold decisions needed to finally bring the WHO into the 21st century and ensure its future. Without this kind of push from the outside, the WHO's future as a global health leader could be anemic at best.

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